Exhibit G

Inmate Request Form dated January 24, 2006

GENEVA COUNTY JAIL
INMATE REQUEST FORM

NAME [illegible] CELL [illegible] DATE 01-24-06

TELEPHONE CALL ____ MEDICAL ✓ DENTAL ____ HEARING REQUEST ____

GRIEVANCE ____ VISIT ____ PERSONAL PROBLEM ____ OTHER ____

SHERIFF ____ JAIL ADMINSTRATOR ____ JUDGE ____ NOTARY ____

BRIEFLY OUTLINE YOUR REQUEST AND GIVE TO THE JAILER/MATRON.

[illegible]

DO NOT WRITE BELOW!! *FOR SHERIFF'S DEPARTMENT USE ONLY*

ALL REQUESTS WILL BE ROUTED THROUGH JAILER/MATRON

JAILER ____ MARTON ____ JAIL ADMINISTRATOR ____ SHERIFF ____

JAILER ____ DATE ____ TIME ____
SIGNATURE

TO BE PLACED IN INMATE'S FILE

1-24-06 CALL SAMSON 7:45 AM

Exhibit H

Wiregrass Medical Center Records dated January 24, 2006

WIREGRASS MEDICAL CENTER 1200 W MAPLE AVE GENEVA AL 36340

EXPECT DATE 1/24/06

EMERGENCY ROOM • OUTPATIENT RECORD

PATIENT NUMBER	TYPE	PATIENT NAME	AGE	BIRTHDATE	SEX	M/S	DATE OF SERVICE	TIME	CLERK INIT.
529459	3	JONES EMMITT	44	4/22/1961	M	DB	1/24/06	09:56	GDC

ADDRESS - LINE 1	ADDRESS - LINE 2	CITY	STATE	ZIP CODE	TELEPHONE
308 S LINE ST		SAMSON	AL	36477	334-684-9978

PATIENT SSAN	NOTIFY IN CASE OF EMERGENCY - NAME	RELATIONSHIP	ADDRESS	TELEPHONE
416887530	ENGRAM KEISAH	DAUGHTER	AL	334-684-9978

INSURANCE COMPANY	CONTRACT OR GROUP NUMBER	DATE	PLACE
		TIME	EVENT

ACCIDENT GUARANTOR

GUARANTOR NAME	GUARANTOR ADDRESS	CITY	STATE	ZIP CODE	GUAR. TELEPHONE
JONES EMMITT	308 S LINE ST	SAMSON	AL	36477	684-9978

GUARANTOR EMPLOYER	GUARANTOR OCCUPATION	GUAR. EMPLOYER ADDRESS	GUAR. EMPL TELEPHONE
INMATE			

PREV. SERVICE	PREV. SERV. DATE	IF MINOR - PARENT NAME	MED. REC. #	ADMITTING/2ND PHYSICIAN
528747	1/13/06		416887530	POPE DAVID/

CHARGES	X-RAY	LAB	RESP. TH.	PHY. TH.	EKG	I.V.	DRUGS	SUPPLIES	OTHER	M.D.	E.R. RM	TOTAL DUE

AUTHORIZATION FOR TREATMENT, GUARANTEE OF PAYMENT , ASSIGNMENT OF INSURANCE BENEFITS

1. The undersigned has been informed of the emergency treatment considered necessary for the above named patient, and that treatment and procedures will be performed by physicians, members of house staff and employees of the hospital. Authorization is hereby granted for such treatment and procedures. The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance has been made as to the results that may be obtained.
2. The undersigned agrees to pay for services rendered by Hospital upon release of patient.
3. I/we hereby assign any hospital benefits, sick benefits, injury benefits due to a liability of a Third party, payable by any party, for the above patient, to Hospital unless I pay the account in full upon release of patient.
4. I/we hereby authorize the "Administrator of Hospital" to furnish from its records any information requested by the before mentioned insurance companies in connection with the above assignment. I do hereby appoint the "Controller" of Hospital as my lawful attorney to endorse for me any checks made payable to me for benefits or claims collected under the above assignment and to apply any credit balance to any other account I may owe said hospital.

DATE TIME SIGNED PATIENT SIGNED GUARANTOR

CHIEF COMPLAINT (If Accident State How, When, and Where)

TEMP.	PULSE	RESP.	B/P	ALLERGIES	MEDICATIONS - HOME	E.R. PHYSICIAN	TET. TOX.

NURSES NOTES:

NURSE'S SIGNATURE (RN OR LPN)

LAB DATA (Including X-Rays, EKGs, etc.)

PHYSICIAN'S REPORT

DIAGNOSIS:

TREATMENT:

CONDITION ON DISC: IMP | STABLE | EXPIRED

INSTRUCTIONS TO PATIENT:

FOLLOW-UP WITH M.D.

M.D.

PATIENT'S SIGNATURE ON DISCHARGE DATE - TIME OF DISC. PHYSICIAN'S SIGNATURE

Wiregrass Medical Center
1200 W. Maple Avenue
Geneva, Alabama 36340

529459

James Emmett

CONDITIONS FOR TREATMENT

1. **MEDICAL AND SURGICAL CONSENT FOR TREATMENT:** The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to furnish the necessary treatment, surgical procedures, anesthesia, x-ray examinations or treatments, drugs and supplies as may be ordered or requested by the attending physician(s). The undersigned acknowledges that no guarantee or assurance has been made as to the results of treatment, surgery or examinations in the hospital. The undersigned recognizes that all physicians furnishing services to the patient may be independent contractors and are not employees or agents of the Hospital.

2. **RELEASE OF INFORMATION:** The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to release to any insurers, their representatives or other third parties confidential information (including copies of records) relative to this hospitalization. This authorization includes, but is not limited, to the release of information relating to drug, alcohol and or psychiatric treatment as specified in Federal Regulation 42, CFR part 2. I further authorize any physician or institution that attended the patient previously to furnish medical records or information which may be requested by the Hospital or attending physicians.

3. **RELEASE FROM LIABILITY FOR VALUABLES:** I have been made aware the WIREGRASS MEDICAL CENTER provides facilities for the safe keeping of my valuables and therefore, I release the Hospital from any responsibility due to loss or damage of my clothing, money, jewelry, or other items of value that I might keep at my bedside, or that may be brought to me by my friends and relatives.

4. **GUARANTOR AGREEMENT:** The undersigned agrees, whether he signs as agent or patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the Hospital in accordance with the regular rates and terms of the Hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts bear interest at the legal rate.

5. **ASSIGNMENT OF INSURANCE BENEFITS:** In the event the undersigned and/or patient is entitled to Hospital benefits of any type whatsoever arising out of any insurance policy or any other party liable to the patient, such benefits are hereby assigned to WIREGRASS MEDICAL CENTER for application to the patient's bill. It is agreed that the Hospital may receipt for any such payment and such payment will discharge the said insurance company of all obligations under the policy to the extent of such payment. The undersigned and/or patient agrees to be responsible for charges not paid by this assignment.

THE UNDERSIGNED CERTIFIES THAT HE HAS READ OR HAD THE FOREGOING INFORMATION EXPLAINED, HAS RECEIVED A COPY, AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Date 1-24 2006

X James Emmett
Patient

Witness Gloria Cu

Patient's Agent or Representative

Relationship to Patient

ASSIGNMENT OF MEDICARE BENEFITS:
PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST

"I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services or authorize such physician or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for Part A deductible for each spell of illness, the Part B deductible for each year, the remaining 20% of reasonable charges and any personal charges incurred."

Date | Signature | Relationship to Patient

ACKNOWLEDGEMENT OF MEDICARE

I hereby declare I am a participant in the Medicare Program and I am not enrolled in a health maintenance organization, (H.M.O.), or any other pre-paid group practice. I understand that if it is found that I am a participant in any of the above mentioned practices, I will be considered a self-pay patient required to pay in full immediately.

Date | Signature | Relationship to Patient

Coding Summary Form

Patient Name:	JONES, EMMITT	**Facility:**	Wiregrass Medical Center	**Payor:**	PB1, PRIVATE PAY DEMAND BILL
MRN:	416887530	**Admission Dx:**	723.1	**Reimbursement:**	
Account #:	529459	**Admission Date:**	01/24/2006	**DRG:**	
Sex:	M	**Discharge Date:**	01/24/2006	**MDC:**	
DOB:	04/22/1961	**LOS:**	1	**Weight:**	
Age:	44y	**Attending Provider:**	008500, POPE, DAVID	**AMLOS:**	
Patient Type:	O			**GMLOS:**	
Visit Type:	O	**Discharge Status:**	01, Discharged to home or self-care (routine discharge)	**Coding Status:**	Complete

Dx	Code	Description
1	723.1	Cervicalgia
2	380.10	Infective Otitis Externa NOS
3	E888.9	Unspecified Fall

Px	Code	Description	Date	Surgeon

CPT	Code	Description	Modifier	SVC Date	Surgeon

Notes

Note Type	Assigned Date	Memo

Coder: **TRACEY** 01/25/2006

(8)

JONES EMMITT E.R.
529459 POPE DAVID HYATT
DOB-04/22/61 44 MALE
01/24/06
ER/ROOM

Emmitt Jones
4-~~24~~ 22-61

Wiregrass Medical Center
ER Triage Record

Addressograph ( ) Emergent ( ) Urgent (✓) Non-Emergent

Triage Notes: c/c swelling + pain of ... left ... onset last night, c/o pain in neck from falling 2 years ago + 2 weeks ago

Time: 0948
Temp: 97.9
Pulse: 64
SpO2: 96%
Resp: 16
Room Air: (✓)
BP: 134/94

Allergies: NKDA

O2:

Tetanus: Weight: 170 lbs LMP:

Family Physician: None

RN Signature: [signature]

Current Medications	**Dose**	**Frequency**	**Last Dose**
Celebrex	1	daily	this am ~~...~~
B/P pill	1	daily	this am

Disposition: Home(✓) Dr. Office() Surgery () Expired() Adm Rm# AMA/LWBS() Date/Time: 1-24-06 1055

Transfer to C/O Dr. Via

WIREGRASS MEDICAL CENTER
EMERGENCY PHYSICIAN RECORD

NECK / BACK
INJURY / PAIN

JONES EMMITT E.R.
522459 POPE DAVID HYATT
DOB-04/22/61 44 MALE
01/24/06
ER/ROOM

(8)

Time Seen: ________ Room: Exam
Historian: patient / EMS / ________
History limited by: ________ ☐ Translator

CHIEF COMPLAINT: (1) ☑ injury / pain to neck (2) Painful swelling of (L) ear
☐ injury / pain to back

HISTORY OF PRESENT ILLNESS:
age: 44 race: W / B / H / O gender: M / F
onset: 12 hrs / days / weeks
☑ h/o previous neck / back injury or pain
Timing: ☑ continues in ED ☐ improved ☐ resolved
Severity of pain: mild moderate severe
pain scale (1—10): 7
Location of pain: R / L neck paraspinal muscles midline R > L
R / L thoracic / lumbosacral
Radiation of pain: ☐ none
☐ arm / hand R / L
☐ buttocks / thigh / leg / foot
Associated injury: yes / no where? ________

Cause of injury: ☑ fall ☐ bending ☐ lifting ☐ twisting / turning
C-Spine X-Rays on 1/13/06 report: Moderately severe cervical spondylosis

Work Related Injury: Yes / No
Exacerbation of pain: ☐ nothing ☐ movement
☐ cough / sneeze ☐ standing
Associated symptoms: ☐ none
☐ paresthesia / numbness
☐ neck pain

Tetanus status: ☐ current ☐ > 5 yrs
ADDITIONAL HISTORY:

PMH/SH/FH ☐ Reviewed on nurse's notes and agree

PAST MEDICAL HISTORY ☑ none ~~~~~~~~ HTN
☑ HTN ☐ asthma ☐ arthritis ☐ diabetes
☐ other: ________

SOCIAL HISTORY
☐ alcohol ☐ tobacco ☐ drug abuse
☑ lives alone / spouse / family / nursing home (Jail)

MEDICATIONS ☐ *see nurse's notes*
☐ *NSAID*
Celebrex
BP Pill (?)

ALLERGIES ☐ *see nurse's notes* ☑ NKDA

REVIEW OF SYSTEMS
☑ *ROS: ALL SYSTEMS REVIEWED & NEGATIVE EXCEPT AS INDICATED*
☐ *ROS cannot be obtained; patient unable to answer questions*
Check box if system is normal:

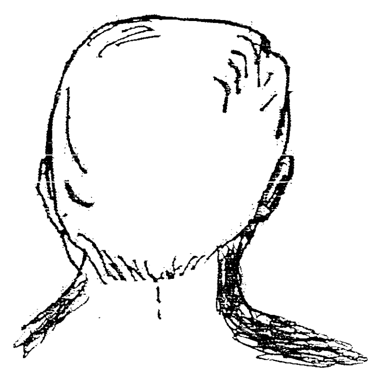
☐ General:	☐ fever	☐ chills		
☐ ENT:	☐ sore throat	☐ earache	☐ URI sx	
☐ Eyes:	☐ visual complaints			
☐ Resp:	☐ cough	☐ SOB / DOE		
☐ CV:	☐ chest pain			
☐ GI:	☐ nausea	☐ vomiting	☐ diarrhea	☐ abd pain
☐ GU:	☐ flank pain	☐ dysuria / frequency / hematuria		
☑ Skeletal:	*see HPI*			
☐ Skin:	☐ rash			
☐ Neuro:	☐ focal weakness	☐ focal sensory loss	☐ paresthesia	
☐ Endocrine:	☐ polyuria	☐ polydypsia	☐ weight change	

PHYSICAL EXAM ☐ vital signs reviewed ☐ VS stable
HR 64 Bp 134/94 RR 16 T 97.9 SaO_2 % 96

APPEARANCE:
☑ normal ☐ distressed: mild / moderate / severe

HEENT
☐ normal
upper 1/3 (L) external ear red swollen, tender + Lump

NECK
☐ non-tender ☑ tender paraspinal muscles (R / L) R > L
☐ full ROM ☐ tender midline
☐ no muscle spasm ☑ muscle spasm (R / L)
mild moderate severe
☑ decreased ROM
☐ cervical adenopathy



BACK
☑ non-tender ☐ tender paraspinal muscles R / L
☑ full ROM ☐ tender midline
☑ no muscle spasm ☐ muscle spasm R / L
mild moderate severe
☐ decreased ROM
☐ pain on leg raising
Right: ____ *degrees*
Left: ____ *degrees*

ABDOMEN: GI / GU
☑ soft ☐ distended
☑ non-tender ☐ tender
☑ no aortic bruit ☐ aortic bruit
☐ CVA tenderness

JONES EMMITT E.D.
520459 POPE DAVID HYATT
DOB-04/22/61 44 MALE
01/24/06

ER/ROOM

Addressograph

Wiregrass Medical Center
Emergency Department
Nursing Assessment

Mode of Arrival: ☑ Ambulatory ☐ Stretcher ☐ Ambulance ☐ Arms ☐ Other:

Accompanied By: ☐ Self ☐ Family/Friend ☑ Police ☐ Other
Immunizations up to date? ☐ Y ☐ N NA

Developmental Age Same as Stated Age ☐ Yes ☐ No NA

How do you prefer to learn? Written ☐ Verbal ☐ Combination ☑

Initial Contact Time: 0948 Allergies: NKDA
Date: 1-24-06

Treatment PTA

None ☑ Cervical Collar ☐ Spineboard: ☐ Splint ☐ Dressings ☐ _____
IV Fluids: _____ Rate: _____ Site: _____
Airway: None ☐ Oral ☐ ET Tube ☐ ☐ Oxygen _____ via ☐ NC ☐ Mask

Nutritional Assessment

Are you on a regular diet? ☑ Y ☐ N
Have you had a recent weight loss or gain? ☐ Y ☑ N
Comments: _____

Respiratory

Respirations: ☑ Regular ☐ Irregular ☐ Shallow ☐ Deep
Breath Sounds: ☐ Bil. Clear ☐ Rhonchi ☐ Rales ☐ Wheezes
Cough: "a little" ☐ Productive ☑ Nonproductive
Sternal Retractions? ☐ Yes ☐ No
Dyspnea? ☐ Yes ☐ No
Comments: _____

Circulation

Skin: ☐ Warm ☑ Dry ☐ Hot ☐ Diaphoretic ☐ Cold ☐ Clammy
Color: ☑ Normal ☐ Pink ☐ Dusky ☐ Flushed ☐ Pale ☐ Cyanotic ☐ Jaundice
Edema: ☑ Yes ~~☐ No~~ NM
JVD: ☐ Yes ☑ No
Capillary Refill: ☑ Quick ☐ Slow
Comments: Lacerations to LUE

Glasgow Coma Scale

Eyes Open:	Spontaneously	4
	To Verbal Command	3
	To Pain	2
	No Response	1
Best Motor Response	Obeys	6
	Localizes Pain	5
	Flexion-Withdrawal	4
	Flexion/Abnormal (Decorticate Rigidity)	3
	Extension (Decerebrate Rigidity)	2
	No Response	1
Best Verbal Response	Oriented/Converses	5
	Disoriented/Converses	4
	Inappropriate Words	3
	Incomprehensible Sounds	2
	No Response	1

GCS Total (3-15): 15

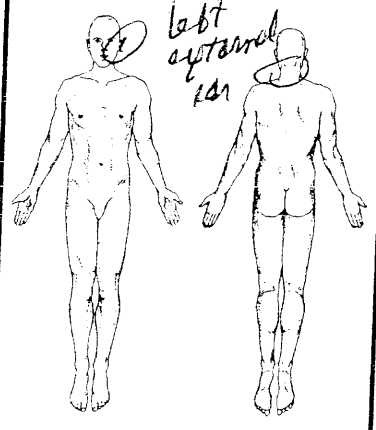
Neurological

Level of Consciousness: ☑ Alert ☐ Responds to Voice ☐ Responds to Pain ☐ Unresponsive ☐ Lethargic
Orientation: ☑ Appropriate Response ☐ Inappropriate Response
Pupils: Brisk ☐ L ☐ R Sluggish ☐ L ☑ R Nonreactive ☐ L ☐ R
Size: L: _____ R: _____
Visual Acuity: ☐ N/A OD: _____ OS: _____
Movement: ☑ Voluntary ☐ Involuntary
Hand Grasp: L R Strong ☐ ☐ Weak ☐ ☐ Absent ☐ ☐
Slurred Speech? ☐ Yes ☐ No

Abdominal

☐ Distended ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ LBM: _____
Bowel Sounds: ☐ Present ☐ Absent
Comments: NA

Pain/Injury Location



Location (circled above)
Radiation (arrow above)

Laceration (s)

Location(s): _____
Size(s): _____
Bleeding Controlled: ☐ Yes ☐ No
Comments: NA
Full Range of Motion ☐ Y ☐ N
Pulse: _____ ☐ Y ☐ N
Sensation Intact: ☐ Y ☐ N

GU-GYN

Pain in Voiding: ☐ Yes ☐ No
Frequency ☐ Yes ☑ No
Bleeding: ☐ Yes ☐ No
Vaginal Bleeding ☑ Yes ☐ No
Vaginal Discharge ☐ Yes ☐ No ☐ Scant ☐ Moderate ☐ Large
Grav____ Para____ Ab____
Comments: _____

Orthopedic

Ext Deformity: ☐ Yes ☑ No
Full ROM: ☐ Yes ☐ No
Pulse: _____
Cap. Refill: ☐ Brisk ☐ Slow
Temp: ☐ Warm ☐ Cold
Sensation Intact: ☐ Yes ☐ No

Emotional Assessment

Eye Contact ☑ Y ☐ N
Affect: ☑ Normal ☐ Flat ☐ Cooperative ☐ Disoriented ☐ Combative ☐ Anxious

Do you feel safe in your present living environment?
☐ Yes ☐ No
If no, would you like to talk to someone? ☐ Yes ☐ No
Comments: Presently incarcerated

Pain Cont'd

Severity: 0 1 2 3 4 5 6 7 8 9 10
Exacerabated By: Nothing
Relieved By: Nothing ☐ Pt unable to rate

Nurse's Signature

[signature]

HOSPITAL
PHYSICIAN ORDER FORM : *GENERAL MEDICAL*

JONES EMMITT E.
529459 POPE DAVID HYATT
DOB - 04/22/61 44 MALE
01/24/06

LABORATORY ORDERS

Order Time	*LAB TEST*	Time Order Sent
	CBC	
	BMP	
	CMP	
	PT / PTT	
	Cardiac profile	
	Liver profile	
	Amylase	
	Lipase	
	Serum preg test	
	Urinalysis	
	Urine C & S	
	Urine preg test	
	Blood cultures	
	Thyroid profile	
	drug levels:	

RADIOLOGY ORDERS

Order Time	*X-RAY*	Time Order Sent
	KUB	
	Abd - flat / upright	
	CXR— PA/lateral	
	IVP	
	US: ☐ GB ☐ aorta ☐ kidney ☐ pancreas	
	CT scan: ☐ abdomen ☐ pelvis ☐ head	
	contrast: ☐ IV ☐ po ☐ none	

CARDIOPULMONARY

Order Time	*TEST*	Time Order Sent
	EKG	
	ABG	
	Sputum gm stain/C&S	

NURSING PROCEDURES

ER/ROOM

- ☐ Cardiac monitor
- ☐ Pulse Oximetry
- ☐ Continuous BP monitoring
- ☐ Oxygen :
- ☐ Foley Catheter
- ☐ NGT tube
- ☐ Intravenous line
  - ☐ hep lock ☐ fluid:
  - RATE:
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐

MEDICATION ORDERS

Order time	MEDICATION	Admin time	Nurse	Comments / ReAssessment

DISCHARGE INSTRUCTIONS

NURSE SIGNATURE

PA /NP SIGNATURE

PHYSICIAN SIGNATURE M. Pope, MD

WIREGRASS MEDICAL CENTER

1200 W. MAPLE AVE.
GENEVA, AL 36340
(334) 684-3655

ED-OP
HOME INSTRUCTION SHEET

1. MEDICAL RECORD NO.	2. BILLING NO.	3. A/R NO.

INFORMATION

4. CLASS	5. DATE	6. TIME	7. SRC	8. TYPE	9. SAD

10. PATIENTS LEGAL NAME (L,F,MI)	11. SEX	12. RACE	13. BIRTHDATE	14. AGE	15. HEIGHT	16. WEIGHT	17. SS	18. MS	19.

20. RP	21. NOTIFY IN EMERGENCY	22. HOME TELE	23. WORK TELE	24. HOW PATIENT ARRIVED

25. C COMPLAINT 26

OUTPATIENT SURGERY INFORMATION

27. PROC CD	28. PROCEDURE	29. LOC	30. TIME	31. ANES

32. PHYSICIAN CALLED	33. ATTENDING PHYSICIAN	34. FAMILY PHYSICIAN
E.R. JONES EMMITT		

529459 POPE DAVID HYATT
DOB 04/22/61 44 MALE
01/24/06

SPRAIN, FRACTURE, & SEVERE BRUISES

- ☐ Elevate the injured part above level of heart to lessen swelling. If pillows flatten, use chair cushions with pillows or blanket for comfort.
- ☐ Ice packs also help prevent swelling, especially during the first 48 hours.
- ☐ Place ice in plastic or rubber bag, cloth covering; after 48 hours, use heat.
- ☐ If you have an elastic bandage, rewrap it if too tight or loose. Remove at bedtime and replace in A.M.
- ☐ If you have a cast, keep it perfectly dry at all times.
- ☐ Wiggle toes or fingers to help prevent swelling in the cast–this should be done often if it does not cause pain.
- ☐ If the part swells anyway or gets cold, blue or numb or pain increases markedly, have it checked promptly.
- ☐ Use crutches.

BACK AND NECK INJURY INSTRUCTIONS

- ☐ USE HEAT OR COLD ON THE INJURED AREA - whichever seems to help the most. Be careful not to burn yourself.
- ☐ Rest as much as possible until you are improved.
- ☐ Avoid positions and movement that make the pain worse.
- ☐ Relax emotionally - if you are tense the problem will on be worse.
- ☐ Gentle but firm massage will increase circulation in sore muscles and helps to clear the soreness.
- ☐ Wear special collar when out of bed.

HEAD INJURY INSTRUCTIONS

Persons who receive blows to the head may have injuries that cannot always be seen by X-ray or examination soon after accident. For the next 24 hours it is important that these instructions be followed:

- ☐ Awaken the patient every two hours, even at night, to be sure he knows where he is and is not confused.
- ☐ Check eyes to see that both pupils are of equal size.
- ☐ Prevent the taking of sleeping pills, tranquilizers or alcohol.
- ☐ Restrict excessive work or play.

Call your family doctor or local hospital immediately if the patient:

- ☐ Develops a severe headache.
- ☐ Vomits more than twice within a short time.
- ☐ Is confused, faints or is hard to awaken.
- ☐ Has a pupil of one eye larger that the other
- ☐ Complains of double vision
- ☐ Shows abnormal behavior such as staggering or walking into things.

X-RAY INSTRUCTIONS

Your X-rays have been read by the attending physician in the Emergency Dept. For your added protection, your X-rays will be reread the next morning by Radiology Dept. If any abnormalities are found that have not been called to your attention, you and your doctor will be called immediately. (Please be certain that the Emergency Dept. has a phone number where you can be reached.) Sometimes fractures or abnormalities may not show up on X-rays for several days. If your symptoms continue or get worse, call your doctor. More X-rays may need to be taken. If you are referred to another physician, come by the hospital and pick up your X-ray and take them with you to the doctor's office. Please call ahead to X-ray Dept.

WOUND CARE (Cuts, Abrasions, Burns, Stitches)

- ☐ Keep the dressings clean and dry.
- ☐ Elevate the wound to help relieve soreness and help speed wound healing.
- ☐ Despite the greatest care, any wound can be infected. If your wound becomes red, swollen, shows pus or red streaks, or feels more sore instead of less sore as days go by, you must report to your doctor right away.
- ☐ Dressing should be changed in _____ days.
- ☐ Treatment rendered _____.
- ☐ Tetanus Toxiod given _____. 250 units of tetanus immune globulin was given. To complete your immunization, you must receive two additional doses of toxoid 4-6 weeks apart. Call your physician for the next dose.
- ☐ Warm soaks to area 4 times daily. 20-40 minutes each time.
- ☐ Continuous warm compresses.

VOMITING & DIARRHEA

- ☐ Do not feed anything for 4 hours.
- ☐ After 4 hours, if there is not vomiting and/or diarrhea, offer 2 tablespoons (1 ounce) of any of the following: clear liquids, Coke, Gingerale, 7-up, weak tea, Gatorade or Jello, water. If patient is hungrey you may add 1 teaspoon of sugar to each ounce of liquid.
- ☐ UNDER NO CIRCUMSTANCES USE MILK OR MILK PRODUCTS.
- ☐ The 2 tablespoons of liquid may be offered every hour. If after 4 hours no vomiting has occured, the amount may be slowly increased.
- ☐ Using no more than ½ glass (4 ounces) of liquid at a time continue this treatment for 24 hours.
- ☐ Contact your doctor's office for further instructions after 24 hours.

GENERAL INSTRUCTIONS

- ☐ Stay in bed/may go to bathroom.
- ☐ Use vaporizor.
- ☐ Drink large amounts of liquids.
- ☐ Take _____ aspirin every 4 hours..
- ☐ Avoid any use of injured part.
- ☐ Allow only limited use of the part.
- ☐ You need not necessarily limit activity.
- ☐ Fill Prescriptions given to you from Emergency Dept. and take as directed.
- ☐ No driving or any activity requiring mental alertness after receiving medication.

FEVER OVER 102

- ☐ Sponge with lukewarm water in the tub.
- ☐ If temperature increases or persists for 24 hours, see your family doctor.

EYE INJURY

- ☐ Any eye injury is potentialiy hazardous.
- ☐ Any increasingly severe discomfort, redness or sudden impairment of vision should be reported immediately to your physician or eye specialist below.
- ☐ Do not drive with eye patch.

ANIMAL OBSERVATION

Instructions for observation of any animal that may have bitten a human if that animal is available for observation.

- ☐ Have animal taken to Vetennarian for observation.
- ☐ If the owner should refuse to take the animal to the Vetennarian, notify the County Health Officer of the situation.

ADDITIONAL INSTRUCTIONS Continue present Medications, May apply Heat to Neck for pain

I hereby acknowledge receipt of all the instructions indicated above. I understand that I have received EMERGENCY treatment only and that I may be released before al my medical problems are known or treated. I will arrange for follow-up care as indicated above. I understand that if my conditions worsen or new symptoms appear, I should contact my Doctor immediately.

PATIENT/PARENT'S SIGNATURE E Emmitt Jones NURSE'S SIGNATURE PHYSICIAN'S SIGNATURE

SCHOOL AND WORK EXCUSE

PATIENT NAME DATE

- ☐ No work for _____ days
- ☐ Light work for _____ days
- ☐ May return to work on _____
- ☐ No school for _____ days
- ☐ No Physical Education for _____ days
- ☐ May return to school on _____

WIREGRASS MEDICAL CENTER

ADVANCE DIRECTIVE
ACKNOWLEDGEMENT

NAME: Emmett Jones SOC. SEC. NO: 416887530
IDENTIFICATION NO: 529459 DATE OF BIRTH: 4-22-61

PLEASE READ THE FOLLOWING FOUR STATEMENTS.

1. I have been given written materials about my right to accept or refuse medical treatments

2. I have been informed of my rights to formulate Advance Directives.

3. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility.

4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:

☐ **I HAVE** executed an Advance Directive.

☒ **I HAVE NOT** executed an Advance Directive.

Signed X Emmett Jones Date: _____

Witness: _____ Date: _____

Witness: Gloria Cox Date: 1-24-06

JONES EMMITT E.R.
529459 POPE DAVID HYATT
DOB-04/22/61 44 MALE
01/24/06

ER/ROOM

Wiregrass Medical Center
ER Level of Service Charge Sheet

		Circulatory
		Jugular,Cutdown, Central Line
	19636430	Blood Administration
	19692960	Cardioversion, Mechanical
	19692950	Code Blue
	19692953	External Pacemaking
	19631500	Intubation
	19690471	Vacine Admin. (other than Rabies)
	19690675	Vacine Administration (Rabies)
	19690784	Medication Administration IV
	19690782	Medication Administration IM or SQ
	19690780	IV infusion-up to 1 hour
	19690781	IV infusion-each additional hour
	19649080	Paracentesis
		Peritoneal Lavage/Tap
	19632000	Thoracentesis
	19633010	Pericardiocentesis
	19632002	Chest Tube Insertion
		IV Hydration
		ENT
		Eye Irrigation
		Eye Exam/Corneal Abrasion
		Foreign Body Removal Ear
		Foreign Body Removal Nose
		Irrigation Ear
		Nose Bleed/Nasal Packing
		Rust Ring (Foreign Body Removal)
		Respiratory
	19631603	Tracheotomy
	19631605	Cricothyrotomy
	19631603	Trach Change
		Gastrointestinal
	19691105	Gastric Lavage or NGT insertion
	19643760	Gastrostomy Tube Placement
		Genitourinary
	19659409	Delivery/Birth
		Supra Pubic Cath, or Turkey Tray
	19651700	Irrigation of Catheter
		Pelvic Exam

		Integumentary
	19611760	Repair of Nail Bed
	19611740	Subungal Hematoma
		Dressing Application
	19610120	FB removal
	19620000	I&D Abcess
	19600000	Laceration Repair (simple,intermed)
	19610000	Laceration Complex
	19611040	Debridement
	19616020	Treatment of Burns
		Orthopedics
		Behr Block/Regional Block
	19629500	Casting/Splinting
	19629705	Removal or Revision of Cast
		Tx of fx/dislocation with manipulation
	19620950	Compartmental Syndrome
		Neurological
	19662290	Lumbar Puncture
		Other
	19682962	Glucose fingerstick
		Treatment Level

19699211	Low Level E/R
19699281	Emergency WD
19699282	Emergency I
	Emergency I with procedure
19699283	Emergency II
	Emergency II with procedure
19699284	Emergency III
	Emergency III with procedure
19699285	Emergency IV
	Emergency IV with procedure
19699291	Critical Care
	Critical Care with procedure
	Observation I
	Observation II
	Observation III

Wiregrass Medical Center
Emergency Physician's Charge Sheet

Date: _____

JONES EMMITT
529459 POPE DAVID HYATT
DOB-04/22/61 44 MALE
01/24/06

ER/ROOM

E.R

Level of Service	
19599281	Level I
19599282	Level II
19599283	Level III
19599284	Level IV
19599285	Level V
19599288	Direct Life Support In Transit
19599025	Visit with Surgery
19599291	Critical Care per Hour
19599292	Critical Care per 1/2 hour
19591105	NG Lavage/Aspiration
19599175	Ipecac Admin/Observe Gastric emptying

Airway/Pulmonary	
19531500	Endotracheal Intubation
19531511	FB Removal
19532020	Tube Thoracostomy

Vascular Procedures	
19536410	Non-Routine Venipuncture
19590780	IV Therapy Requiring MD per hour
19592977	Thrombolysis IV infusion

Cardiac Procedures	
19592950	CPR
19592953	Transcutaneous Pacing
19592960	Cardioversion, Elective
19593010	EKG Interpretation

Ophthalmology	
19565205	FB
19565210	FB Conjunctival/Embedded
19567938	FB, Eyelid

Ear,Nose, and Throat	
19542809	FB Pharynx
19569200	FB External Ear Canal
19569210	Impacted Cerumen
19530300	FB Intranasal
19530901	Anterior Epitaxis, Simple
19530903	Anterior Epitaxis, Complex
19530905	Posterior Epitaxis, Initial

Soft Tissue/Foreign Body Removal	
19510120	Sub Q, Simple
19510121	Sub Q, Complicated
19520520	Muscle, Simple
19520525	Muscle, Complex

Nails	
19511730	Avulsion/Nail, Simple
19512740	Subungal Hematoma
19511750	Nail Removal

Debridement	
19511000	Infected Skin
19511040	Partial Skin Thickness
19511041	Skin, Full Thickness
19511042	Skin and Sub Q Tissue
19511043	Skin, Sub Q, Muscle
19511044	Skin, Sub Q, Muscle, Bone

Hematoma and Abcess	
19510060	I&D Simple Abcess, Furuncle
19510061	I&D Simple Abcess, Complicated/ Multiple
19510140	I&D Hematoma Simple
19510160	I&D Puncture Aspiration, Abcess
19546320	Hemorrhoid, Thrombosed

Burns	
19516000	First Degree Burn, Initial
19516020	Small Burn, Debride,Dress
19516025	Medium Burn, Debride/Dress
19516030	Large Burn, Debride/Dress

OB/GYN Procedures	
19556405	I&D, Abcess, Vulva
19556420	I&D, Bartholin Abcess
19559410	Emergency Vaginal Delivery

Arthrocentesis	
19520600	Arthrocentesis, Small Joint
19520605	Arthrocentesis, Intermediate Joint
19520610	Arthrocentesis, Major Joint

Miscellaneous Fractures	
19521800	Closed Rib Fracture
19523500	Clavicle
19523720	Closed Phalangeal Shaft
19526750	Closed Distal Phalangeal
19528490	Closed Fracture, Great Toe
19528510	Closed Phalanx other than Gr. Toe

Miscellaneous Closed Dislocations	
19521480	TMJ Uncomplicated
19523650	Shoulder w/ Manipulation
19524640	Nursemaid's Elbow
19526700	Finger, MP Joint
19526770	Finger, IP Joint
19528660	Toe IP Joint

Miscellaneous Procedures	
19553670	Urine Catheterization, Simple
19553675	Urine Catheterization, Complex
19562270	Spinal Puncture
19564450	Digital Block
19582270	Stool for Occult Blood
19593042	Rhythm Strip Interpretation

Repair/Simple- Single Layer	
Scalp, Neck, Axillae, External Genitalia, Trunk, and/or extremities	
19512001	2.5 cm or less
19512002	2.6 - 7.5 cm
19512004	7.6 - 12.5 cm
19512005	12.6 - 20.0 cm
19512006	20.1 - 30.0 cm

Repair/Simple- Single Layer Cont'd	
Face, Ears, Eyelids, Nose, Lips, and/or Mucous Membranes	
19512011	2.5 cm or less
19512013	2.6 - 5.0 cm
19512014	5.1-7.5 cm
19512015	7.6 - 12.5 cm
19512016	12.6 - 20.0 cm
19512017	20.1 - 30.0 cm
19512018	Over 30.0 cm
19512020	Superficial WD Dehis
19512021	Superficial WD Dehis-Pack

Repair/Intermediate-Layered	
Scalp, Axillae, Trunk, and/or Extremities	
19512031	2.5 cm or less
19512032	2.6 - 7.5 cm
19512034	7.6 - 12.5 cm
19512035	12.6 - 20.0 cm
19512036	20.1 - 30.0 cm
19512037	Over 30.0 cm
Neck, Hand, Feet, and/or External Genitalia	
19512041	2.5 cm or less
19512042	2.6 - 7.5 cm
19512044	7.6- 12.5 cm
19512045	12.6 - 20.0 cm
19512046	20.0 - 30.0 cm
19512047	Over 30.0 cm
Face, Ears, Eyelids, Nose, Lips, and/or Mucous Membranes	
19512051	2.5 cm or less
19512052	2.6 - 5.0 cm
19512053	5.1 - 7.5 cm
19512054	7.6 - 12.5 cm
19512055	12.6 - 20.0 cm
19512056	20.1 - 30.0 cm
19512057	Over 30.0 cm

Repair/Complex-Reconstructive or Complicated Wound Closure	
Trunk	
19513100	1.1 - 2.5 cm
19513101	2.6 - 7.5 cm
Scalp, Arms, and/or Legs	
19513120	1.1 - 2.5 cm
19513121	2.6 - 7.5 cm
Forehead, Cheeks, Chin, Mouth, Neck, Axillae, Genitalia, Hands, and or Feet	
19513132	1.1 - 7.5 cm
Eyelids, Nose, Ears, and/or Lips	
19513151	1.1 - 2.5 cm
19513152	2.6 - 7.5 cm

Miscellaneous	
19520552	Injection-trigger point 1-2 mus.
19520553	Injection-trigger point 3 + mus.

Exhibit I

Inmate Request Form dated January 24, 2006

GENEVA COUNTY JAIL
INMATE REQUEST FORM

NAME Emmitt Jones CELL 45 DATE 1/22/06

TELEPHONE CALL ____ MEDICAL X DENTAL ____ HEARING REQUEST ____

GRIEVANCE ____ VISIT ____ PERSONAL PROBLEM ____ OTHER ____

SHERIFF ____ JAIL ADMINSTRATOR ____ JUDGE ____ NOTARY ____

BRIEFLY OUTLINE YOUR REQUEST AND GIVE TO THE JAILER/MATRON.

Need to call [redacted] Samson

Thank you

DO NOT WRITE BELOW!! *FOR SHERIFF'S DEPARTMENT USE ONLY*

ALL REQUESTS WILL BE ROUTED THROUGH JAILER/MATRON

JAILER ____ MARTON ____ JAIL ADMINISTRATOR ____ SHERIFF ____

JAILER J. Kerlin DATE 1-27-06 TIME 8:15
SIGNATURE

TO BE PLACED IN INMATE'S FILE

Call - Could he said would get someone to take him

Exhibit J

Wiregrass Medical Center Records dated January 27, 2006

WIREGRASS MEDICAL CENTER 1200 W MAPLE AVE GENEVA AL 36340

EXPECT DATE 1/27/06

EMERGENCY ROOM • OUTPATIENT RECORD

PATIENT NUMBER	TYPE	PATIENT NAME	AGE	BIRTHDATE	SEX	M/S	DATE OF SERVICE	TIME	CLERK INIT.
529718	3	JONES EMMITT	44	4/22/1961	M	DB	1/27/06	09:51	GDC

ADDRESS - LINE 1	ADDRESS - LINE 2	CITY	STATE	ZIP CODE	TELEPHONE
308 S LINE ST		SAMSON	AL	36477	334-684-9978

PATIENT SSAN	NOTIFY IN CASE OF EMERGENCY - NAME	RELATIONSHIP	ADDRESS	TELEPHONE
416887530	ENGRAM KEISAH	DAUGHTER	AL	334-684-9978

INSURANCE COMPANY	CONTRACT OR GROUP NUMBER	DATE	PLACE
		TIME	EVENT

ACCIDENT/GUARANTOR

GUARANTOR NAME	GUARANTOR ADDRESS	CITY	STATE	ZIP CODE	GUAR. TELEPHONE
JONES EMMITT	308 S LINE ST	SAMSON	AL	36477	684-9978

GUARANTOR EMPLOYER	GUARANTOR OCCUPATION	GUAR. EMPLOYER ADDRESS	GUAR. EMPL TELEPHONE
NONE			

PREV. SERVICE	PREV. SERV. DATE	IF MINOR - PARENT NAME	MED. REC. #	ADMITTING/2ND PHYSICIAN
529459	1/24/06		416887530	NAEEM MUHA/

CHARGES	X-RAY	LAB	RESP. TH.	PHY. TH.	EKG	I.V.	DRUGS	SUPPLIES	OTHER	M.D.	E.R. RM	TOTAL DUE

AUTHORIZATION FOR TREATMENT, GUARANTEE OF PAYMENT , ASSIGNMENT OF INSURANCE BENEFITS

1. The undersigned has been informed of the emergency treatment considered necessary for the above named patient, and that treatment and procedures will be performed by physicians, members of house staff and employees of the hospital. Authorization is hereby granted for such treatment and procedures. The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance has been made as to the results that may be obtained.
2. The undersigned agrees to pay for services rendered by Hospital upon release of patient.
3. I/we hereby assign any hospital benefits, sick benefits, injury benefits due to a liability of a Third party, payable by any party, for the above patient, to Hospital unless I pay the account in full upon release of patient.
4. I/we hereby authorize the "Administrator of Hospital" to furnish from its records any information requested by the before mentioned insurance companies in connection with the above assignment. I do hereby appoint the "Controller" of Hospital as my lawful attorney to endorse for me any checks made payable to me for benefits or claims collected under the above assignment and to apply any credit balance to any other account I may owe said hospital.

DATE TIME SIGNED PATIENT SIGNED GUARANTOR

CHIEF COMPLAINT (If Accident State How, When, and Where)

TEMP.	PULSE	RESP.	B/P	ALLERGIES	MEDICATIONS - HOME	E.R. PHYSICIAN	TET. TOX.

NURSES NOTES:

NURSE'S SIGNATURE (RN OR LPN)

LAB DATA (Including X-Rays, EKGs, etc.)

PHYSICIAN'S REPORT

DIAGNOSIS:

TREATMENT:

CONDITION ON DISC: IMP | STABLE | EXPIRED

INSTRUCTIONS TO PATIENT:

FOLLOW-UP WITH M.D.

PATIENT'S SIGNATURE ON DISCHARGE
BY SIGNING HERE I CERTIFY THAT I UNDERSTAND THE FOLLOW-UP

DATE - TIME OF DISC.

M.D.
PHYSICIAN'S SIGNATURE

Wiregrass Medical Center
1200 W. Maple Avenue
Geneva, Alabama 36340

52970
James Emmett

CONDITIONS FOR TREATMENT

1. **MEDICAL AND SURGICAL CONSENT FOR TREATMENT:** The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to furnish the necessary treatment, surgical procedures, anesthesia, x-ray examinations or treatments, drugs and supplies as may be ordered or requested by the attending physician(s). The undersigned acknowledges that no guarantee or assurance has been made as to the results of treatment, surgery or examinations in the hospital. The undersigned recognizes that all physicians furnishing services to the patient may be independent contractors and are not employees or agents of the Hospital.

2. **RELEASE OF INFORMATION:** The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to release to any insurers, their representatives or other third parties confidential information (including copies of records) relative to this hospitalization. This authorization includes, but is not limited, to the release of information relating to drug, alcohol and or psychiatric treatment as specified in Federal Regulation 42, CFR part 2. I further authorize any physician or institution that attended the patient previously to furnish medical records or information which may be requested by the Hospital or attending physicians.

3. **RELEASE FROM LIABILITY FOR VALUABLES:** I have been made aware the WIREGRASS MEDICAL CENTER provides facilities for the safe keeping of my valuables and therefore, I release the Hospital from any responsibility due to loss or damage of my clothing, money, jewelry, or other items of value that I might keep at my bedside, or that may be brought to me by my friends and relatives.

4. **GUARANTOR AGREEMENT:** The undersigned agrees, whether he signs as agent or patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the Hospital in accordance with the regular rates and terms of the Hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts bear interest at the legal rate.

5. **ASSIGNMENT OF INSURANCE BENEFITS:** In the event the undersigned and/or patient is entitled to Hospital benefits of any type whatsoever arising out of any insurance policy or any other party liable to the patient, such benefits are hereby assigned to WIREGRASS MEDICAL CENTER for application to the patient's bill. It is agreed that the Hospital may receipt for any such payment and such payment will discharge the said insurance company of all obligations under the policy to the extent of such payment. The undersigned and/or patient agrees to be responsible for charges not paid by this assignment.

THE UNDERSIGNED CERTIFIES THAT HE HAS READ OR HAD THE FOREGOING INFORMATION EXPLAINED, HAS RECEIVED A COPY, AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Date 1-27 20 06

X Emmett James
Patient

Witness Gloria Cu

Patient's Agent or Representative

Relationship to Patient

ASSIGNMENT OF MEDICARE BENEFITS:
PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST

"I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services or authorize such physician or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for Part A deductible for each spell of illness, the Part B deductible for each year, the remaining 20% of reasonable charges and any personal charges incurred."

Date | Signature | Relationship to Patient

ACKNOWLEDGEMENT OF MEDICARE

I hereby declare I am a participant in the Medicare Program and I am not enrolled in a health maintenance organization, (H.M.O.), or any other pre-paid group practice. I understand that if it is found that I am a participant in any of the above mentioned practices, I will be considered a self-pay patient required to pay in full immediately.

Date | Signature | Relationship to Patient

Coding Summary Form

Patient Name:	JONES, EMMITT	**Facility:**	Wiregrass Medical Center	**Payor:**	PB1, PRIVATE PAY DEMAND BILL
MRN:	416887530	**Admission Dx:**	721.0	**Reimbursement:**	
Account #:	529718	**Admission Date:**	01/27/2006	**DRG:**	
Sex:	M	**Discharge Date:**	01/27/2006	**MDC:**	
DOB:	04/22/1961	**LOS:**	1	**Weight:**	
Age:	44y	**Attending Provider:**	941400, NAEEM, MUHAMMED	**AMLOS:**	
Patient Type:	O			**GMLOS:**	
Visit Type:	O	**Discharge Status:**	01, Discharged to home or self-care (routine discharge)	**Coding Status:**	Complete

Dx	Code	Description
1	721.0	Cervical Spondylosis w/o Myelopathy

Px	Code	Description	Date	Surgeon

CPT	Code	Description	Modifier	SVC Date	Surgeon

Notes

Note Type	Assigned Date	Memo

Coder: **TRACEY** 01/31/2006

JONES EMMITT
529718 NAEEM MUHAMMED
DOB-04/22/61 44 MALE
01/27/06

E.R.

F9/ROOM

Jones, E
4-22-61
(8)

Wiregrass Medical Center
ER Triage Record

Addressograph

( ) Emergent ( ) Urgent (~~✓~~) Non-Emergent

Triage Notes: 44 yr old BM presents c/c sudden onset of neck pain this am c/o HA

Time: 0943
Temp: 97.6
Pulse: 62
SpO2: 99% Resp: 18
Room Air: (✓) BP: 163/103
Allergies: NKA
O2:

Tetanus: Weight: LMP:

Family Physician: MD

RN Signature:

Current Medications	Dose	Frequency	Last Dose
Methocarbamol '/24	750	÷ TID	
Cephalexin '/24	500	÷ QID	
Diltiazem '/13		÷ Daily	
Celebrex '/13	200	÷ Daily	

Disposition: Home(✓) Dr. Office() Surgery () Expired() Adm Rm# AMA/LWBS() Date/Time: 1/27/06

Transfer to C/O Dr. Via

(1 of 2)

JONES EMMITT E.R.
522718 NAEEM MUHAMMED
DOB - 04/22/61 44 MALE
01/27/06
ED/ROOM

WIREGRASS MEDICAL CENTER
EMERGENCY PHYSICIAN RECORD

NECK / BACK INJURY / PAIN

Time Seen: 1000 AM Room: _____
Historian: patient / EMS / _____
History limited by: _____ ☐ Translator

CHIEF COMPLAINT: ☐ injury / pain to neck ☐ injury / pain to back

HISTORY OF PRESENT ILLNESS:
age: _____ race: W / B / H / O gender: M / F
onset: _____ hrs / days / weeks
☐ h/o previous neck / back injury or pain
Timing: ☑ continues in ED ☐ improved ☐ resolved
Severity of pain: mild moderate severe
pain scale (1—10): _____
Location of pain: R / L neck paraspinal muscles midline
R / L thoracic / lumbosacral
Radiation of pain: ☐ none
☐ arm / hand R / L
☐ buttocks / thigh / leg / foot
Associated injury: yes / no where? _____

Cause of injury: ☐ fall ☐ bending ☐ lifting ☐ twisting / turning
last time ago. seen in C-spine 1/13/06
ER on 1/27/06. Spondylosis

Work Related Injury: Yes / No
Exacerbation of pain: ☐ nothing ☐ movement ☐ cough / sneeze ☐ standing
Associated symptoms: ☐ none ☐ paresthesia / numbness ☐ neck pain
Tetanus status: ☐ current ☐ > 5 yrs
ADDITIONAL HISTORY:
Mother created 2 years ago
Able to fall.

PMH/SH/FH ☐ Reviewed on nurse's notes and agree

PAST MEDICAL HISTORY ☐ none
☐ HTN ☐ asthma ☐ arthritis ☐ diabetes
☐ other : _____

SOCIAL HISTORY
☐ alcohol ☐ tobacco ☐ drug abuse
☐ lives alone / spouse / family / nursing home
Jail inmate

MEDICATIONS ☑ see nurse's notes
☐ NSAID

ALLERGIES ☑ see nurse's notes ☐ NKDA

REVIEW OF SYSTEMS
☑ *ROS: ALL SYSTEMS REVIEWED & NEGATIVE EXCEPT AS INDICATED*
☐ *ROS cannot be obtained; patient unable to answer questions*
Check box if system is normal:

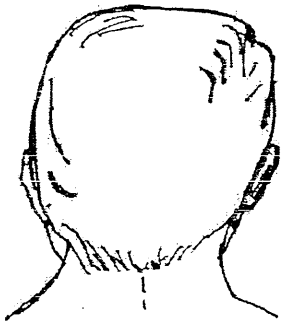
☐ General:	☐ fever	☐ chills		
☐ ENT:	☐ sore throat	☐ earache	☐ URI sx	
☐ Eyes:	☐ visual complaints			
☐ Resp:	☐ cough	☐ SOB / DOE		
☐ CV:	☐ chest pain			
☐ GI:	☐ nausea	☐ vomiting	☐ diarrhea	☐ abd pain
☐ GU:	☐ flank pain	☐ dysuria / frequency / hematuria		
☐ Skeletal:	*see HPI*			
☐ Skin:	☐ rash			
☐ Neuro:	☐ focal weakness	☐ focal sensory loss	☐ paresthesia	
☐ Endocrine:	☐ polyuria	☐ polydypsia	☐ weight change	

PHYSICAL EXAM ☑ vital signs reviewed ☑ VS stable
HR ____ Bp ____ RR ____ T ____ SaO_2 %____

APPEARANCE:
☐ normal ☐ distressed: mild / moderate / severe

HEENT
☑ normal

NECK
☑ non-tender
☐ full ROM
☐ no muscle spasm
☐ tender paraspinal muscles R / L
☐ tender midline
☐ muscle spasm R / L
mild moderate severe
☐ decreased ROM in all directions
☐ cervical adenopathy



BACK
☑ non-tender
☑ full ROM
☑ no muscle spasm
☐ tender paraspinal muscles R / L
☐ tender midline
☐ muscle spasm R / L
mild moderate severe
☐ decreased ROM
☐ pain on leg raising
Right: _____ *degrees*
Left: _____ *degrees*

ABDOMEN: GI / GU
☑ soft
☑ non-tender
☑ no aortic bruit
☐ distended
☐ tender
☐ aortic bruit
☐ CVA tenderness

E.R.

NES EMMITT
971P KAEEM MUHAMMED
-34/22/61 44 MALE
1/27/06

Addressograph

Wiregrass Medical Center
Emergency Department
Nursing Assessment

Mode of Arrival: ☑ Ambulatory ☐ Stretcher ☐ Ambulance ☐ Arms ☐ Other:_____

Accompanied By: ☐ Self ☐ Family/Friend ☑ Police ☐ Other
Immunizations up to date? ☑ Y ☐ N

Developmental Age Same as Stated Age ☐ Yes ☐ No

How do you prefer to learn? Written ☐ Verbal ☐ Combination ☑

Initial Contact Time: 1943 Allergies: NKDA
Date: 1/27/06

Treatment PTA

None ☐ Cervical Collar ☐ Spineboard: ☐ Splint ☐ Dressings ☐ R2
IV Fluids:_____ Rate:_____ Site:_____
Airway: None ☐ Oral ☐ ET Tube ☐ ☐ Oxygen _____ via ☐ NC ☐ Mask

Nutritional Assessment

Are you on a regular diet? ☑ Y ☐ N
Have you had a recent weight loss or gain? ☐ Y ☐ N
Comments:_____

Respiratory

Respirations: ☐ Regular ☐ Irregular ☐ Shallow ☐ Deep
Breath Sounds: ☐ Bil. Clear ☐ Rhonchi ☐ Rales ☐ Wheezes
Cough: ☐ Productive ☐ Nonproductive
Sternal Retractions? ☐ Yes ☐ No
Dyspnea? ☐ Yes ☐ No
Comments:_____

Circulation

Skin: ☐ Warm ☐ Dry ☐ Hot ☐ Diaphoretic ☐ Cold ☐ Clammy
Color: ☑ Normal ☐ Pink ☐ Dusky ☐ Flushed ☐ Pale ☐ Cyanotic ☐ Jaundice
Edema: ☐ Yes ☐ No
JVD: ☐ Yes ☐ No
Capillary Refill: ☐ Quick ☐ Slow
Comments:_____

Glasgow Coma Scale

Eyes Open: Spontaneously 4; To Verbal Command 3; To Pain 2; No Response 1
Best Motor Response: Obeys 6; Localizes Pain 5; Flexion-Withdrawal 4; Flexion/Abnormal (Decorticate Rigidity) 3; Extension (Decerebrate Rigidity) 2; No Response 1
Best Verbal Response: Oriented/Converses 5; Disoriented/Converses 4; Inappropriate Words 3; Incomprehensible Sounds 2; No Response 1
GCS Total (3-15): 15

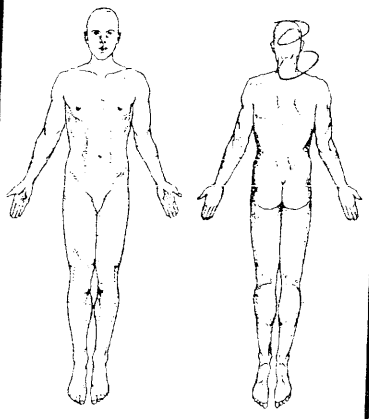
Neurological

Level of Consciousness: ☐ Alert ☐ Responds to Voice ☐ Responds to Pain ☐ Unresponsive ☐ Lethargic
Orientation: ☑ Appropriate Response ☐ Inappropriate Response
Pupils: Brisk ☐ L ☐ R; Sluggish ☐ L ☐ R; Nonreactive ☐ L ☐ R
Size: L:_____ R:_____
Visual Acuity: ☑ N/A
OD:_____ OS:_____
Movement: ☑ Voluntary ☐ Involuntary
Hand Grasp: L R; Strong ☐ ☐; Weak ☐ ☐; Absent ☐ ☐
Slurred Speech? ☐ Yes ☐ No

Abdominal

☐ Distended ☐ Nausea
☐ Vomiting ☐ Diarrhea
☐ Constipation ☐ LBM:_____
Bowel Sounds: ☐ Present ☐ Absent
Comments:_____

Pain/Injury Location



Location (circled above)

Radiation (arrow above)

Laceration (s)

Location(s):_____
Size(s):_____
Bleeding Controlled: ☐ Yes ☐ No
Comments:_____

GU-GYN

Pain in Voiding: ☐ Yes ☐ No
Frequency ☐ Yes ☐ No
Bleeding: ☐ Yes ☐ No
Vaginal Bleeding ☐ Yes ☐ No
Vaginal Discharge ☐ Yes ☐ No
☐ Scant ☑ Moderate ☐ Large
Grav_____ Para_____ Ab_____
Comments:_____

Pain Cont'd

Severity:_____
0 1 2 3 4 5 6 7 8 9 10
Exacerbated By:_____
Relieved By:_____ ☐ Pt unable to rate

Orthopedic

Full Range of Motion ☐ Y ☐ N
Pulse:_____ ☐ Y ☐ N
Sensation Intact: ☐ Y ☐ N
Ext Deformity: ☐ Yes ☐ No
Full ROM: ☑ Yes ☐ No
Pulse:_____
Cap. Refill: ☐ Brisk ☐ Slow
Temp: ☑ Warm ☐ Cold
Sensation Intact: ☐ Yes ☐ No

Emotional Assessment

Eye Contact ☐ Y ☐ N
Affect: ☐ Normal ☐ Flat ☐ Cooperative ☐ Disoriented ☐ Combative ☐ Anxious

Do you feel safe in your present living environment? ☐ Yes ☐ No
If no, would you like to talk to someone? ☐ Yes ☐ No
Comments:_____

Nurse's Signature

JONES EMMITT
529719 NAEEM MUHAMMED
DOB-04/22/61 44 MALE
01/27/06
F7/POD

HOSPITAL
PHYSICIAN ORDER FORM : *GENERAL MEDICAL*

LABORATORY ORDERS

Order Time	*LAB TEST*	Time Order Sent
	CBC	
	BMP	
	CMP	
	PT / PTT	
	Cardiac profile	
	Liver profile	
	Amylase	
	Lipase	
	Serum preg test	
	Urinalysis	
	Urine C & S	
	Urine preg test	
	Blood cultures	
	Thyroid profile	
	drug levels:	

RADIOLOGY ORDERS

Order Time	*X-RAY*	Time Order Sent
	KUB	
	Abd - flat / upright	
	CXR— PA/lateral	
	IVP	
	US: ☐ GB ☐ aorta ☐ kidney ☐ pancreas	
	CT scan: ☐ abdomen ☐ pelvis ☐ head contrast: ☐ IV ☐ po ☐ none	

CARDIOPULMONARY

Order Time	*TEST*	Time Order Sent
	EKG	
	ABG	
	Sputum gm stain/C&S	

NURSING PROCEDURES

- ☐ Cardiac monitor
- ☐ Pulse Oximetry
- ☐ Continuous BP monitoring
- ☐ Oxygen :
- ☐ Foley Catheter
- ☐ NGT tube
- ☐ Intravenous line
  - ☐ hep lock ☐ fluid:
  - RATE:
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐

MEDICATION ORDERS

Order time	MEDICATION	Admin time	Nurse	Comments / ReAssessment
	Inj Toradol 60 mg IM NOW		R.N.	

DISCHARGE INSTRUCTIONS

F/U by physician at Jail

NURSE SIGNATURE R.N.

PA /NP SIGNATURE

PHYSICIAN SIGNATURE

WIREGRASS MEDICAL CENTER

1200 W. MAPLE AVE.
GENEVA, AL 36340
(334) 684-3655

ED-OP
HOME INSTRUCTION SHEET

1. MEDICAL RECORD NO.	2. BILLING NO.	3. AIR NO.

INFORMATION

4. CLASS	5. DATE	6. TIME	7. SRC	8. TYPE	9. SAD

10. PATIENTS LEGAL NAME (L,F,MI)	11. SEX	12. RACE	13. BIRTHDATE	14. AGE	15. HEIGHT	16. WEIGHT	17. SS	16. MS	19.
JONES EMMITT 529718 NAEEM MUHAMMED E.R.									

20. RP	21. NOTIFY IN EMERGENCY	22. HOME TELE	23. WORK TELE	24. HOW PATIENT ARRIVED
	DOB-04/22/61 01/27/06	44 MALE		

25. C COMPLAINT 26.	27. PROC CD	28. PROCEDURE	29. LOC	30. TIME	31. ANES
ED/BOOH					

OUTPATIENT SURGERY INFORMATION

32. PHYSICIAN CALLED	33. ATTENDING PHYSICIAN	34. FAMILY PHYSICIAN

SPRAIN, FRACTURE, & SEVERE BRUISES

- ☐ Elevate the injured part above level of heart to lessen swelling. If pillows flatten, use chair cushions with pillows or blanket for comfort.
- ☐ Ice packs also help prevent swelling, especially during the first 48 hours.
- ☐ Place ice in plastic or rubber bag, cloth covering; after 48 hours, use heat.
- ☐ If you have an elastic bandage, rewrap it if too tight or loose. Remove at bedtime and replace in A.M.
- ☐ If you have a cast, keep it perfectly dry at all times.
- ☐ Wiggle toes or fingers to help prevent swelling in the cast--this should be done often if it does not cause pain.
- ☐ If the part swells anyway or gets cold, blue or numb or pain increases markedly, have it checked promptly
- ☐ Use crutches.

BACK AND NECK INJURY INSTRUCTIONS

- ☐ USE HEAT OR COLD ON THE INJURED AREA - whichever seems to help the most. Be careful not to burn yourself.
- ☐ Rest as much as possible until you are improved.
- ☐ Avoid positions and movement that make the pain worse.
- ☐ Relax emotionally - if you are tense the problem will on be worse.
- ☐ Gentle but firm massage will increase circulation in sore muscles and helps to clear the soreness.
- ☐ Wear special collar when out of bed.

HEAD INJURY INSTRUCTIONS

Persons who receive blows to the head may have injuries that cannot always be seen by X-ray or examination soon after accident. For the next 24 hours it is important that these instructions be followed:

- ☐ Awaken the patient every two hours, even at night, to be sure he knows where he is and is not confused.
- ☐ Check eyes to see that both pupils are of equal size.
- ☐ Prevent the taking of sleeping pills, tranquilizers or alcohol.
- ☐ Restrict excessive work or play.

Call your family doctor or local hospital immediately if the patient:

- ☐ Develops a severe headache.
- ☐ Vomits more than twice within a short time.
- ☐ Is confused, faints or is hard to awaken.
- ☐ Has a pupil of one eye larger that the other
- ☐ Complains of double vision
- ☐ Shows abnormal behavior such as staggering or walking into things.

X-RAY INSTRUCTIONS

Your X-rays have been read by the attending physician in the Emergency Dept. For your added protection, your X-rays will be reread the next morning by Radiology Dept. If any abnormalities are found that have not been called to your attention, you and your doctor will be called immediately. (Please be certain that the Emergency Dept. has a phone number where you can be reached.) Sometimes fractures or abnormalities may not show up on X-rays for several days. If your symptoms continue or get worse, call your doctor. More X-rays may need to be taken. If you are referred to another physician, come by the hospital and pick up your X-ray and take them with you to the doctor's office. Please call ahead to X-ray Dept.

WOUND CARE (Cuts, Abrasions, Burns, Stitches)

- ☐ Keep the dressings clean and dry.
- ☐ Elevate the wound to help relieve soreness and help speed wound healing.
- ☐ Despite the greatest care, any wound can be infected. If your wound becomes red, swollen, shows pus or red streaks, or feels more sore instead of less sore as days go by, you must report to your doctor right away.
- ☐ Dressing should be changed in _____ days.
- ☐ Treatment rendered _____.
- ☐ Tetanus Toxiod given _____. 250 units of tetanus immune globulin was given. To complete your immunization, you must receive two additional doses of toxoid 4-6 weeks apart. Call your physician for the next dose.
- ☐ Warm soaks to area 4 times daily. 20-40 minutes each time.
- ☐ Continuous warm compresses.

VOMITING & DIARRHEA

- ☐ Do not feed anything for 4 hours.
- ☐ After 4 hours, if there is not vomiting and/or diarrhea, offer 2 tablespoons (1 ounce) of any of the following: clear liquids, Coke, Gingerale; 7-up, weak tea, Gatorade or Jello, water. If patient is hungrey you may add 1 teaspoon of sugar to each ounce of liquid.
- ☐ UNDER NO CIRCUMSTANCES USE MILK OR MILK PRODUCTS.
- ☐ The 2 tablespoons of liquid may be offered every hour. If after 4 hours no vomiting has occured, the amount may be slowly increased.
- ☐ Using no more than ½ glass (4 ounces) of liquid at a time continue this treatment for 24 hours.
- ☐ Contact your doctor's office for further instructions after 24 hours.

GENERAL INSTRUCTIONS

- ☐ Stay in bed/may go to bathroom.
- ☐ Use vaporizor.
- ☐ Drink large amounts of liquids.
- ☐ Take _____ aspirin every 4 hours..
- ☐ Avoid any use of injured part.
- ☐ Allow only limited use of the part.
- ☐ You need not necessarily limit activity.
- ☐ Fill Prescriptions given to you from Emergency Dept. and take as directed.
- ☐ No driving or any activity requiring mental alertness after receiving medication.

FEVER OVER 102

- ☐ Sponge with lukewarm water in the tub.
- ☐ If temperature increases or persists for 24 hours, see your family doctor.

EYE INJURY

- ☐ Any eye injury is potentially hazardous.
- ☐ Any increasingly severe discomfort, redness or sudden impairment of vision should be reported immediately to your physician or eye specialist below.
- ☐ Do not drive with eye patch.

ANIMAL OBSERVATION

Instructions for observation of any animal that may have bitten a human if that animal is available for observation.

- ☐ Have animal taken to Vetennarian for observation.
- ☐ If the owner should refuse to take the animal to the Vetennarian, notify the County Health Officer of the situation.

ADDITIONAL INSTRUCTIONS Continue Current Medication — Wear Soft collar — Follow up with MD as needed

I hereby acknowledge receipt of all the instructions indicated above. I understand that I have received EMERGENCY treatment only and that I may be released before al my medical problems are known or treated. I will arrange for follow-up care as indicated above. I understand that if my conditions worsen or new symptoms appear, I should contact my Doctor immediately.

PATIENT/PARENT'S SIGNATURE: X Emmitt Jones | NURSE'S SIGNATURE | PHYSICIAN'S SIGNATURE

SCHOOL AND WORK EXCUSE PATIENT NAME DATE

- ☐ No work for _____ days
- ☐ Light work for _____ days
- ☐ May return to work on _____
- ☐ No school for _____ days
- ☐ No Physical Education for _____ days
- ☐ May return to school on _____

WIREGRASS MEDICAL CENTER PHYSICIAN'S SIGNATURE

ADVANCE DIRECTIVE
ACKNOWLEDGEMENT

NAME: Emmitt Jones SOC. SEC. NO: 416877530
IDENTIFICATION NO: 529718 DATE OF BIRTH: 4-22-61

PLEASE READ THE FOLLOWING FOUR STATEMENTS.

1. I have been given written materials about my right to accept or refuse medical treatments

2. I have been informed of my rights to formulate Advance Directives.

3. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility.

4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:

☐ **I HAVE** executed an Advance Directive.

☒ **I HAVE NOT** executed an Advance Directive.

Signed X Emmitt Jones Date: _____

Witness: _____ Date: _____

Witness: Gloria Cox Date: 1-27-06

JONES EMMITT E.R.
529718 NAEEM MUHAMMED
DOB-04/22/61 44 MALE
01/27/06

ER/ROOM

Wiregrass Medical Center
ER Level of Service Charge Sheet

		Circulatory
		Jugular,Cutdown, Central Line
	19636430	Blood Administration
	19692960	Cardioversion, Mechanical
	19692950	Code Blue
	19692953	External Pacemaking
	19631500	Intubation
	19690471	Vacine Admin. (other than Rabies)
	19690675	Vacine Administration (Rabies)
	19690784	Medication Administration IV
	19690782	Medication Administration IM or SQ
	19690780	IV infusion-up to 1 hour
	19690781	IV infusion-each additional hour
	19649080	Paracentesis
		Peritoneal Lavage/Tap
	19632000	Thoracentesis
	19633010	Pericardiocentesis
	19632002	Chest Tube Insertion
		IV Hydration
		ENT
		Eye Irrigation
		Eye Exam/Corneal Abrasion
		Foreign Body Removal Ear
		Foreign Body Removal Nose
		Irrigation Ear
		Nose Bleed/Nasal Packing
		Rust Ring (Foreign Body Removal)
		Respiratory
	19631603	Tracheotomy
	19631605	Cricothyrotomy
	19631603	Trach Change
		Gastrointestinal
	19691105	Gastric Lavage or NGT insertion
	19643760	Gastrostomy Tube Placement
		Genitourinary
	19659409	Delivery/Birth
		Supra Pubic Cath, or Turkey Tray
	19651700	Irrigation of Catheter
		Pelvic Exam

		Integumentary
	19611760	Repair of Nail Bed
	19611740	Subungal Hematoma
		Dressing Application
	19610120	FB removal
	19620000	I&D Abcess
	19600000	Laceration Repair (simple,intermed)
	19610000	Laceration Complex
	19611040	Debridement
	19616020	Treatment of Burns
		Orthopedics
		Behr Block/Regional Block
	19629500	Casting/Splinting
	19629705	Removal or Revision of Cast
		Tx of fx/dislocation with manipulation
	19620950	Compartmental Syndrome
		Neurological
	19662290	Lumbar Puncture
		Other
	19682962	Glucose fingerstick
		Treatment Level
	19699211	Low Level E/R
	19699281	Emergency WD
	19699282	Emergency I
		Emergency I with procedure
✓	19699283	Emergency II
		Emergency II with procedure
	19699284	Emergency III
		Emergency III with procedure
	19699285	Emergency IV
		Emergency IV with procedure
	19699291	Critical Care
		Critical Care with procedure
		Observation I
		Observation II
		Observation III

JONES EMMITT
529718 NAEEM MUHAMMED
DOB-04/22/61 44 MALE
01/27/06

ER/ROOM

Wiregrass Medical Center
Emergency Physician's Charge Sheet

E. P. Date:

Level of Service

19599281	Level I
19599282	Level II ✓
19599283	Level III
19599284	Level IV
19599285	Level V
19599288	Direct Life Support In Transit
19599025	Visit with Surgery
19599291	Critical Care per Hour
19599292	Critical Care per 1/2 hour
19591105	NG Lavage/Aspiration
19599175	Ipecac Admin/Observe Gastric emptying

Airway/Pulmonary

19531500	Endotracheal Intubation
19531511	FB Removal
19532020	Tube Thoracostomy

Vascular Procedures

19536410	Non-Routine Venipuncture
19590780	IV Therapy Requiring MD per hour
19592977	Thrombolysis IV infusion

Cardiac Procedures

19592950	CPR
19592953	Transcutaneous Pacing
19592960	Cardioversion, Elective
19593010	EKG Interpretation

Ophthalmology

19565205	FB
19565210	FB Conjunctival/Embedded
19567938	FB, Eyelid

Ear,Nose, and Throat

19542809	FB Pharynx
19569200	FB External Ear Canal
19569210	Impacted Cerumen
19530300	FB Intranasal
19530901	Anterior Epitaxis, Simple
19530903	Anterior Epitaxis, Complex
19530905	Posterior Epitaxis, Initial

Soft Tissue/Foreign Body Removal

19510120	Sub Q, Simple
19510121	Sub Q, Complicated
19520520	Muscle, Simple
19520525	Muscle, Complex

Nails

19511730	Avulsion/Nail, Simple
19512740	Subungal Hematoma
19511750	Nail Removal

Debridement

19511000	Infected Skin
19511040	Partial Skin Thickness
19511041	Skin, Full Thickness
19511042	Skin and Sub Q Tissue
19511043	Skin, Sub Q, Muscle
19511044	Skin, Sub Q, Muscle, Bone

Hematoma and Abcess

19510060	I&D Simple Abcess, Furuncle
19510061	I&D Simple Abcess, Complicated/ Multiple
19510140	I&D Hematoma Simple
19510160	I&D Puncture Aspiration, Abcess
19546320	Hemorrhoid, Thrombosed

Burns

19516000	First Degree Burn, Initial
19516020	Small Burn, Debride,Dress
19516025	Medium Burn, Debride/Dress
19516030	Large Burn, Debride/Dress

OB/GYN Procedures

19556405	I&D, Abcess, Vulva
19556420	I&D, Bartholin Abcess
19559410	Emergency Vaginal Delivery

Arthrocentesis

19520600	Arthrocentesis, Small Joint
19520605	Arthrocentesis, Intermediate Joint
19520610	Arthrocentesis, Major Joint

Miscellaneous Fractures

19521800	Closed Rib Fracture
19523500	Clavicle
19523720	Closed Phalangeal Shaft
19526750	Closed Distal Phalangeal
19528490	Closed Fracture, Great Toe
19528510	Closed Phalanx other than Gr. Toe

Miscellaneous Closed Dislocations

19521480	TMJ Uncomplicated
19523650	Shoulder w/ Manipulation
19524640	Nursemaid's Elbow
19526700	Finger, MP Joint
19526770	Finger, IP Joint
19528660	Toe IP Joint

Miscellaneous Procedures

19553670	Urine Catheterization, Simple
19553675	Urine Catheterization, Complex
19562270	Spinal Puncture
19564450	Digital Block
19582270	Stool for Occult Blood
19593042	Rhythm Strip Interpretation

Repair/Simple- Single Layer

Scalp, Neck, Axillae, External Genitalia, Trunk, and/or extremities

19512001	2.5 cm or less
19512002	2.6 - 7.5 cm
19512004	7.6 - 12.5 cm
19512005	12.6 - 20.0 cm
19512006	20.1 - 30.0 cm

Repair/Simple- Single Layer Cont'd

Face, Ears, Eyelids, Nose, Lips, and/or Mucous Membranes

19512011	2.5 cm or less
19512013	2.6 - 5.0 cm
19512014	5.1-7.5 cm
19512015	7.6 - 12.5 cm
19512016	12.6 - 20.0 cm
19512017	20.1 - 30.0 cm
19512018	Over 30.0 cm
19512020	Superficial WD Dehis
19512021	Superficial WD Dehis-Pack

Repair/Intermediate-Layered

Scalp, Axillae, Trunk, and/or Extremities

19512031	2.5 cm or less
19512032	2.6 - 7.5 cm
19512034	7.6 - 12.5 cm
19512035	12.6 - 20.0 cm
19512036	20.1 - 30.0 cm
19512037	Over 30.0 cm

Neck, Hand, Feet, and/or External Genitalia

19512041	2.5 cm or less
19512042	2.6 - 7.5 cm
19512044	7.6- 12.5 cm
19512045	12.6 - 20.0 cm
19512046	20.0 - 30.0 cm
19512047	Over 30.0 cm

Face, Ears, Eyelids, Nose, Lips, and/or Mucous Membranes

19512051	2.5 cm or less
19512052	2.6 - 5.0 cm
19512053	5.1 - 7.5 cm
19512054	7.6 - 12.5 cm
19512055	12.6 - 20.0 cm
19512056	20.1 - 30.0 cm
19512057	Over 30.0 cm

Repair/Complex-Reconstructive or Complicated Wound Closure

Trunk

19513100	1.1 - 2.5 cm
19513101	2.6 - 7.5 cm

Scalp, Arms, and/or Legs

19513120	1.1 - 2.5 cm
19513121	2.6 - 7.5 cm

Forehead, Cheeks, Chin, Mouth, Neck, Axillae, Genitalia, Hands, and or Feet

19513132	1.1 - 7.5 cm

Eyelids, Nose, Ears, and/or Lips

19513151	1.1 - 2.5 cm
19513152	2.6 - 7.5 cm

Miscellaneous

19520552	Injection-trigger point 1-2 mus.
19520553	Injection-trigger point 3 + mus.